Virginia Department of Health
Division of Tuberculosis Control

Newcomer Health Program

Six Year Report January 1998-December 2003

Each year thousands of persons leave their homelands to settle in new and distant lands. Among these are refugees who are defined as persons forced to flee his/her country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Many refugees spend months or years in hastily set up refugee camps, awaiting the right to return home or to resettle in a new country kind enough to provide long-term refuge. The United States (U.S.) has a long history of accepting refugees from around the world. During the years following World War II, refugees have been designated a distinct class of legal immigrants, who based on social or political criteria, are designated as in need of humanitarian protection and safe haven.

The term refugee is used throughout this document and refers to the following eligible immigrant groups:

- *Refugees* are defined in the previous paragraph.
- *Asylees* are defined as foreign nationals that cannot return to their country of origin or residence because of a well-founded fear of persecution because of race, nationality, and membership in a particular social group. A*sylees* apply for and receive this status *after* entering the U.S., while refugees apply for and receive their status *before* entering the U.S.
- *Cuban and Haitian Entrants* are defined as persons of Cuban or Haitian origin granted parole status or special status under U.S. immigration laws.
- *Amerasians* are defined as persons of Asian and American descent, primarily children fathered by American servicemen and born between 1/1/1962 and 1/1/1976.
- *Unaccompanied Minors* are defined as refugee children (under 18 years of age) that arrive in the U.S. unaccompanied by a parent or other close adult relative and will required foster care.
- *Victims of Trafficking* are persons who have been victim of sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or persons that have been recruited, harbored, transported etc for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. This group was included in the refugee group as of 2000.

Each of these groups will have a different legal status as listed on their I-94 card a U.S. Citizen and Immigration Service (USCIS) document. *Victims of Trafficking* are provided a letter of certification instead of an I-94. All are eligible for benefits administered by the Office of Refugee Resettlement (ORR) in the US Department of Health and Human Services. In the U.S., many refugees are assisted in their resettlement process by humanitarian or faith-based voluntary agencies (VOLAGs). Funding available through ORR assists these agencies with the resettlement process.

Under the Federal Refugee Act of 1980, a uniform system of services was created for refugees resettling in the U.S. The purpose of this act was “to provide for the effective resettlement of refugees” and “to assist them to achieve economic self-sufficiency as quickly as possible”. Among the benefits provided to refugees under this Act is a comprehensive health assessment, which should be performed as soon after arrival as possible and which is designed to identify and eliminate health related barriers to successful resettlement while protecting the health

of the U.S. population. Federal Refugee Medical Assistance (RMA) funds are provided to each state to underwrite the cost of these medical assessments.

The Office of Newcomer Services, which administers the federal RMA funds in Virginia, works through the Virginia Department of Health (VDH), Division of Tuberculosis Control (DTC), Newcomer Health Program (NHP) to coordinate, facilitate, and monitor the provision of initial health assessment services to newly arrived refugees. Through a preventive health grant ORR provides funding to the NHP to maintain necessary infrastructure. Because tuberculosis (TB) infection and disease are common health problems observed in the refugee population, the Virginia NHP became a part of the Division of TB Control (DTC) in 1997.

All immigrants (any person entering the U.S. as a lawful permanent resident (LPR)) are required by law to undergo medical examination *overseas, prior* to their resettlement in the U.S. Refugees also must receive this medical examination prior to U.S entry. The examination is designed to identify certain medical conditions that may deny the person entry into the U.S. Presently, these *excludable conditions* are defined as:

- A communicable disease of public health significance (*e.g.* potentially infectious tuberculosis, certain sexually transmitted diseases, HIV infection/AIDS, Hansen's disease)
- A current or past physical or mental disorder that is associated with harmful behavior
- Drug abuse or addiction.

Identification of an excludable condition during the overseas examination results in assignment of a "classification". Persons designated with a "Class A" condition cannot enter the U.S. Although the presence of any of these diseases, termed as *excludable conditions,* prevents the granting of an entry visa, a waiver process exists for non-refugee immigrants, with some "Class A" conditions. If an applicant with HIV infection, for example, can demonstrate the means to financially support his or her health care in the U.S., a waiver for entry may be issued. Refugees, with HIV infection, are admitted on a case-by-case basis, also with a waiver while the financial support for their health care may be covered under RMA funds or other public funds. There is no waiver provision for visa applicants with drug abuse or addiction.

The system for classifying individuals with tuberculosis is more complex. Those with potentially infectious tuberculosis (defined by the presence of positive smears) are designated "Class A" tuberculosis. These persons are required to begin treatment overseas and when non-infectious they may reapply for an entry visa, with a waiver. Persons with evidence of active tuberculosis on chest radiograph but negative sputum smears, are designated as "Class B1" tuberculosis, while those who have radiographic evidence of inactive tuberculosis are "Class B2" tuberculosis.

In 1996, the U.S. Congress amended the Immigration and Nationality Act (INA) and revised the health related grounds of inadmissibility. A subsection, *Proof of Vaccination Requirements for Immigrants*, was added, which requires any alien who seeks an immigrant visa or an adjustment to status as a LPR to present proof of vaccination against certain vaccine preventable diseases. Refugees must comply with this requirement by the time they apply for adjustment of status, one year after arrival into the U.S.

In the U.S., quarantine stations are located at eight major international airports. Each station has responsibility for all ports of entry in an assigned geographic area. All arriving passengers and crew are observed for signs and symptoms of illness. Passengers meeting certain criteria may be questioned or detained. Arriving aliens (immigrants and refugees) particularly

those with Class A or B classifications will have their medical documents and immunization records reviewed for completeness. Refugees normally arrive at entry ports where quarantine inspectors are assigned, but this may not always be the case. If a quarantine inspector is not available, an immigration inspector will review the refugees' documents and report the information to the station that covers that geographic area. Immigrants and refugees with classified health conditions are reminded, at the port of entry, that they need to report to the local health department where they intend to resettle, for an evaluation of that classified health condition. Refugees are reminded to report to the local health department for an initial health assessment. The quarantine stations will then send a "Notification of Arrival" and the alien's medical documentation to the state health department in which the immigrant or refugee has indicated they will resettle.

In Virginia, the NHP receives these Notifications of Arrival and medical information, for all refugees and any immigrant with a classified health condition entering the state. Since 1997, the NHP has entered demographic information from these notifications into a program database, prior to their distribution to the local health district. This refugee database has allowed for tracking of refugee arrivals to the various health districts within Virginia. The database also collects basic health information so that emerging health trends in this population may be identified.

For many years, local health districts in Virginia have provided some level of health assessment services to newly arriving refugees. These services had been paid for by the refugee or out of local health district budgets. With incorporation of the NHP into DTC, a statewide protocol for the Refugee Health Assessment that included a standardized health assessment was implemented. The program database also facilitates the reimbursement schedule for the assessment from DSS to the local health districts. The NHP allowed for three Levels to the health assessment, ranging from a complete health assessment to the minimum, an evaluation for tuberculosis. The Program further designed the RMA reimbursement to reflect the level of service provided by districts.

The six-year breakdown of RMA reimbursement to health districts is as follows:

Year	RMA Reimbursement	For Number Refugees
1998	$ 253,164.50	1,035
1999	$ 360,436.00	1,447
2000	$ 435,650.00	1,701
2001	$ 369,789.50	1,328
2002	$ 339,236.00	1,195
2003	$ 246,162.50	833
Totals	*$2,004,438.50*	*7,539*

Level I, the evaluation for tuberculosis disease or infection, includes an assessment for clinical signs and symptoms, placement and reading of a tuberculin skin test, and a chest x-ray and therapy as indicated.
Level II includes a more complete patient inspection or assessment, some laboratory testing as indicted, and an assessment of immunization status.
Level III includes listening for abnormalities of heart and lung sounds and any further testing appropriate for age, such as developmental testing for young children, further evaluation for anemia findings, cardiovascular disease, cancer, and /or sexually transmitted diseases as indicated.

Level IV is case management. Many refugees require some level of case management by a public health nurse and so Level IV was designed to not only to capture these data but also to reimburse health districts for the knowledge and skill required to perform this case management.

For the six-year period from January 1998 through December 2003, 10,891 persons with refugee status have entered the Commonwealth. Of these, 1,817 claim Bosnia & Herzegovina as their country of origin. Other common countries of origin include, Somalia (1,231), Sudan (897), Afghanistan (770), Ethiopia (679), Vietnam (655), Serbia (568), Cuba (536), Sierra Leone (487), Iran (482), Iraq (406), and Liberia (369). The remaining 1,994 (18%) hail from another 79 different countries.

Refugee arrivals by world region for this period:

WHO World Region	Number Refugees	Percent of Total
Africa	2,193	20%
Americas	597	5%
Asia	119	1%
Europe	3,354	31%
Eastern Mediterranean	3,911	36%
Western Pacific	717	7%
Total	*10,891*	*100%*

Of these new refugees, program data indicate the majority, 5,922 (54%) resettled in Northern Virginia, predominately in the counties of Fairfax, Arlington, and Prince William and the city of Alexandria. Central Virginia, predominately Henrico County, became home to 16% of new refugees. This is followed by the northwest region (14%), primarily the Charlottesville and Harrisonburg areas. The southwest region or Roanoke area became home to 944 (9%) refugees. And lastly, the eastern region, Hampton Roads, received 7% of new refugee arrivals for this period.

Refugee arrivals to the Commonwealth by health region:

Health Region	Number Refugees	Percent of Total
Northern	5,922	54%
Central	1,739	16%
Northwest	1,516	14%
Southwest	944	9%
Eastern	770	7%
Total	*10,891*	*100%*

Of refugees received in Virginia for this same period, 1,152 or (11%) entered with a classified health condition. The breakdown is as follows:

Health Classification	Percent of Total
Tuberculosis Class A	0.009%
Tuberculosis Class B1	0.6%
Tuberculosis Class B2	3%
HIV Infection (Class A)	0.2%
"Other" Class B	7%

"Other" accounts for a number of health conditions such as hypertension, diabetes, cancer, developmental delays, traumatic wounds, amputations, scarring, etc. Class B other does not affect immigration into the U.S.

Program data show that 8,219 (75%) of the total refugees received, a minimum, Level I of the initial health assessment. Twenty-six districts provided these initial health assessments to new refugees. These health assessments were provided anywhere from 6 days to over 3 months, with an average of 32days from the time of arrival into the U.S. That refugees receive a health assessment within 30 days of arrival into the U.S. is an objective that ORR has set for VOLAGs resettling refugees.

Program data also indicate that 1,701 (16%) of refugees did not receive health assessment services from local health districts. Many resettled to another state soon after arrival into the U.S., some declined a health assessment, some received their health assessment from a private provider, and, while some could not be located. The NHP has no return information for the remaining 9%, so it is unknown whether they received a health assessment.

All 8,219 refugees assessed received a Level I assessment, the evaluation for tuberculosis. Of these, 100 (1.2%) were diagnosed with either suspected or confirmed tuberculosis disease and 4,173 (51%) refugees were diagnosed with latent tuberculosis infection.

Total Assessed	Percent of Total	Suspected Confirmed Disease	Percent of Total	Latent Infection	Percent of Total
8,219	75%	100	1.2%	4173	51%

Of the 8,219 refugees that received a health assessment, 7,042 (86%) received Level II assessments. Level II of the assessment, not only includes a review of necessary immunizations, but also identifies other health problems of this population. The prevalence of these selected health problems are shown here:

n=7042		
Health Problem	Number	Percent of total
Dental	2,646	38%
Vision / Hearing	821	12%
Low weight	506	7.2%
Anemia	481	6.8%
Pregnancy	101	1.4%
Mental delay	30	0.4%

Immunizations needed or provided at the initial health assessment are:

n=7042		
Immunization	Total	Percent of total
Diphtheria/Tetanus/Pertussis	5,340	76%
Polio (IPV)	2,237	32%
MMR	5,302	75%
HIB *		
Hepatitis B	2,716	39%
Varicella	2,833	40%
Pneumococcal	311	4.4%
Influenza	372	5.3%

That refugees receive their required immunizations soon after arrival into the US is another goal VOLAGs strive to meet. Refugees must be vaccinated against all vaccine preventable diseases when they apply for change of status to LPR, once in the U.S. one year.

Note: The HIB immunization is combined with other immunizations. This may account for lack of documentation that any HIB was provided to young children.

For refugees receiving a Level II assessment, follow up referrals for a health need identified are demonstrated in this chart:

n=7042		
Referral Condition	Total number	Percent of Total
Dental	5,208	74%
Immunizations	6,207	88%
Vision/hearing	984	14%
Intestinal/blood parasites	741	11%
Hepatitis	313	4%
Developmental	23	0.3%
Mental Health	86	1%
Other	2,427	34%

Other includes health conditions such as pregnancy, hypertension, diabetes, cancer, and mental health, traumatic wound care or revisions, and so on. These data do not fully represent health needs of the total refugee population because not all health districts provide Level II and III of the health assessment.

In recent years, the arriving refugee population has become more diverse. Considering the many countries of origin, the resources needed to provide services in many languages and dialects is overwhelming for providers. VDH health districts struggle to meet the requirements of Title VI of the Civil Rights Act of 1964. Providing culturally and linguistically appropriate services to clients is a continuing challenge as the U.S. population becomes increasingly diverse. VOLAGs and Virginia's Area Health Education Centers (AHEC) may be of assistance to local health districts, and other health providers, in meeting the health needs of Virginia's new refugees. The web site www.refugee.org/world may also assist providers in understanding our refugees' cultural and needs.

The public health system is uniquely qualified to identify conditions of public health significance. Refugees, as all newcomers to the U.S., must learn to navigate the U.S. health care system, which can be overwhelming to many. A holistic approach to provide health care to this vulnerable population is imperative for the first months in their new country. That health districts provide a detailed assessment of each refugee newcomer is essential to this process. Health districts are encouraged to begin the orientation process to our health care system, while providing referrals to follow up of health programs identified at the assessment. Providing appropriate treatment for TB disease and latent TB infection is but one example of treating the condition, while providing education to the client and protecting the public health.

Immunization of refugees against all vaccine preventable diseases is not only a good public health practice, but also now the law. Refugees are required to change their legal residency one year after arrival into the U.S., at which time they are required to do status show proof of immunizations. Health districts are encouraged to begin providing immunizations as refugees present to them, stressing the need for follow up and maintaining their records. Exploring new partnerships with local private providers for follow up of identified health needs is critical, as health districts no longer provide primary care. Other than tuberculosis conditions, dental health is identified as the most common problem for refugees. Identifying local resources to provide dental care for this group is crucial to oral and over all health.

Mental health has been an identified problem for many refugees. As survival is a coping mechanism for the refugee, the need for mental health care may not manifest until the refugee has

been in the U.S. for a period of time. Districts are encouraged to network with local Community Service Boards (CSB) in providing some of the needed mental care to newcomers. Health professionals are encouraged to be available for counseling and treatment as these needs arise in the refugee. ORR has funded several projects, nationally, to provide services for victims of torture. A Program for Survivors of Torture and Severe Trauma (PSTT) is located in Falls Church, Virginia. Contact the Center for Multi Cultural Human Services at 703-533-3302.

Effective August of 2001, the VDH NHP has had a full time dedicated coordinator. We know this vulnerable population presents a challenge to our local health districts and other providers. Program data do assist in an overall assessment of the program and can help plan for more effective use of program resources. A concern is that all refugees may not be receiving an assessment of their immunization status.

Refugee admissions, like all immigration into the U.S. slowed after the events of September 11, 2001. Each year in October, the president based on recommendations from the Secretary of State, declares the number of refugees the U.S. will accept that year. The Bush administration had declared that the U.S. would accept 70,000 refugees in FY 2002, 2003and 2004; however we did not met this number for either year. For FY 2004, it is probable that 50,000 will be admitted, but in an ever-changing world refugee admissions can change at any time.